Hospitals are strongly encouraged to use the correct and current HCPCS level II codes to report charges for all drugs, biologicals, and radiopharmaceuticals (RPs) furnished (if codes are available), regardless of whether the items are paid separately or packaged. The Centers for Medicare & Medicaid Services (CMS) provided this advice and more in transmittal 2386 (change request [CR] 7672, January 13, 2012)—a revision to transmittal 2376 (December 29, 2011) where the agency summarized 2012 changes to the hospital outpatient prospective payment system (OPPS).

The agency also notes that “precise billing of … HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.”

When you bill for these products, make sure that the units of service you report match the dosages contained in the active 2012 HCPCS level II code descriptors assigned and are consistent with the quantity of the drug, biological, or RP used in the patient’s care. (See Information Sources on page 2 for the link to current level II codes.)

For example, the code and description for DaTscan™ is A9584—iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries. If 5 millicuries of DaTscan is given, you would not bill A9584 x 5, you would bill A9584 x 1 for a single-study dose.

CMS states that reporting HCPCS codes for all drugs, biologicals and RPs furnished may require hospitals to change longstanding reporting practices. Specifically, many hospitals don’t assign codes for these items and, therefore, aren’t getting paid separately. What happens is that when their billers see status indicator “N,” which identifies a packaged product or service, they just don’t bother billing for it because no separate payment will be made. However, this is a short-sighted practice that may lead to CMS eventually deciding that since hospitals do not have to pay for the RP or contrast, it will just remove the cost from the final code payment.

Accurate Data, Accurate Payments

Although most hospital leaders are simply trying to stay afloat in this currently challenging healthcare environment, there is such a thing as “the future,” which is why CMS stresses accurate data. The agency reminds hospitals over and over that more complete and precise data on drugs, biologicals, and RPs provided during an encounter help to improve accuracy for those that are separately payable.

CMS makes packaging determinations annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPPS rates improves when hospitals report charges for all items and services that have HCPCS codes, whether or not payment for the items and services is packaged or not.

It is CMS’s standard rate-setting methodology to rely on hospital cost-and-charge information as it is reported.

Diagnostic RPs

Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic RPs under the OPPS—the difference between the payments for the pass-through product and the predecessor product. The predecessor product is packaged into the payment for the nuclear medicine procedure in which the diagnostic RP is used.

Say, for example, a current radiopharmaceutical costs $100 and that charge is included in the payment for
the CPT code assigned to a nuclear medicine procedure. Then, a new and better RP is developed for that procedure, and it costs $250. The payment “offset” (the additional amount the facility receives) will be $150—the difference between the value already included in the procedure and the additional cost of the new RP.

Effective July 1, 2011, the diagnostic RP reported with the following HCPCS level II code was granted pass-through status under the OPPS (status indicator G), and it will continue on pass-through status through 2012.

A9584   Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries

Continuing on pass-through status means that when A9584 is billed on the same claim with a nuclear medicine procedure, CMS will reduce payment for it by the corresponding nuclear medicine procedure’s APC payment that is associated with “policy-packaged” drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

Therapeutic Radiopharmaceuticals

Since 2010, non-pass-through, separately payable therapeutic radiopharmaceuticals have been paid under the OPPS based upon the average sales price (ASP). If ASP data are unavailable, payment is based upon the hospital’s most recent mean unit cost data. Table 7 in the transmittal provides a list of non-pass-through separately payable therapeutic RPs for January 1, 2012.

Clarifying ASP

Products with pass-through status receive payment based on the ASP plus 6 percent. Those without pass-through status receive the ASP plus 4 percent. In both cases, the associated acquisition cost and pharmacy overhead costs are included in the final payment. ASP rates are updated on a quarterly basis.

Revised Modifier Descriptions

CMS revised the guidance related to use of modifiers 74 and 52 for discontinued services in the Medicare Claims Processing Manual, chapter 4, section 20.6.4.

Facilities use modifier 74 to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the patient’s well-being. The following sentence has been added to the guidance: This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician’s discretion after the administration of anesthesia.

The agency also added the word “cancellation” to the description of modifier 52, so now this modifier indicates partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service.

Payment Window

When there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the three calendar days [or one calendar day for a non-IPPS hospital] prior to the date of an inpatient admission) must be bundled. Therefore, services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were.

Information Sources:

- A list of current HCPCS level II codes can be found at http://cms.gov/Medicare/Medicare.html. From this page, go to the Coding section (in the first column), then HCPCS Release & Code Sets. On the left side, click on Alpha Numeric HCPCS, which brings you to the list for 2012 and previous years.

ICD-10 EFFECTIVE DATE MAY BE EXTENDED AGAIN:

Industry Needs More Time

The Centers for Medicare & Medicaid Services (CMS) published the final rule adopting the ICD-10 coding system (diagnoses and procedures) as a standard in January 2009 and set a compliance date of October 1, 2013—a two-year delay from the compliance date initially specified in the 2008 proposed rule. Facilities and practices have been preparing for this implementation since the rule was adopted.

Then, in November 2011, the American Medical Association’s House of Delegates voted “to work vigorously to stop implementation of ICD-10.” Despite repeated statements that there would be no delay in the implementation of ICD-10, the Department of Health and Human Services (HHS) announced, in February 2012, that it would re-evaluate the timeline for implementation.

On Monday, April 9, 2012, HHS Secretary Kathleen Sebelius announced a proposed rule that would delay the compliance date for ICD-10 implementation from October 1, 2013, to October 1, 2014.

The ICD-10 compliance date change is part of a proposed rule that also would adopt a standard for a unique health plan identifier (HPID), adopt a data element that would serve as an “other entity” identifier (OEID), and add a national provider identifier (NPI) requirement.

In a press release announcing the above, HHS noted that “CMS and HHS believe the change in the compliance date for ICD-10, as proposed in this rule, would give providers and other covered entities more time to prepare and fully test their systems to ensure...”
a smooth and coordinated transition among all industry segments.”

This may, in part, be in response to the problems associated with the 5010 transaction standard that have resulted in two delays of implementation enforcement.

**CASE STUDY: HIDA Scan**

**History:** Abdominal pressure for two years. Increasing tightness and nausea over the last few weeks.

**Comparison:** CT of the abdomen and pelvis from 3/16/2011. Abdominal ultrasound from 3/10/2011.

**Technical Data:** Following the intravenous injection of 5.1 mCi of Tc-99 labeled Choletec, five minute anterior planar images were obtained over the abdomen. At 45 minutes, 1.8 micrograms of sincalide (Kinevac) was slowly infused intravenously. Anterior images were obtained over the gallbladder. Gallbladder ejection fraction was calculated by applying a region of interest over the gallbladder.

**Findings:** Following sincalide injection, the patient’s symptoms were reproduced. The gallbladder ejection fraction was calculated at 82%, which is within the normal range.

The liver demonstrates homogeneous distribution of the radiotracer. The biliary ducts are visualized by 15 minutes. The gallbladder is visualized by 20 and continues to fill. Activity was seen in the small bowel at 40 minutes indicating free passage through the sphincter Oddi.

**Impressions:** 1) Patent cystic duct and common bile duct. 2) Calculated gallbladder ejection fraction of 82%. 3) Reproduction of the patient’s symptoms following the administration of sincalide.

**Code Assignments**

- 78227 Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed
- A9537 Technetium Tc-99M mebrofenin, diagnostic, per study dose, up to 15 millicuries (Choletec)
- J2805 Injection, sincalide, 5 micrograms (Kinevac)

**CODING TIPS: Hepatobiliary System Imaging Study**

During its review of codes, the American Medical Association (AMA) determined that codes 78220 and 78223 no longer reflected current technology and practice and needed to be redefined. As a result, the AMA deleted these codes.

Effective January 1, 2012, the AMA established the following codes:

- 78226 Hepatobiliary system imaging, including gallbladder when present;
- 78227 Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed

As its descriptor indicates, code 78226 is assigned only for imaging. Code 78227 accounts for the additional physician and technical work required to perform a study that includes pharmacological stimulation of the gallbladder and contraction during the study, whether there is quantification of gallbladder or hepatic function.

Imaging and pharmacologic study of the gallbladder is not required with these new codes but is included, if performed, as noted in the code language for 78226 and 78227.

Facilities should remember to code for the radiopharmaceutical and other drugs when provided.

**Q & A: Focus on Nuclear Medicine**

**Can you tell me the code for a HIDA scan?**

You may choose from the following codes:

- 78226 Hepatobiliary system imaging, including gallbladder when present;
- 78227 Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed

If, during the scan, a drug such as Kinevac® is given, you would code 78227. If no drug is given during the exam, assign code 78226.
**Will hospitals be reimbursed for Kinevac®?**

For 2012, HCPCS level II code J2805 (injection, sinalide, 5 micrograms) has a status indicator of “N,” which means it is packaged under the hospital outpatient prospective payment system (OPPS). It is not reimbursed separately by Medicare under OPPS.

**We are now providing a new nuclear medicine scan—78803, octreotide scan with SPECT. Can we also charge 78804 multiple days for additional scans on same patient with a modifier?**

Code 78803 is only for the SPECT scan. If you do a whole body scan in addition to the SPECT, also assign CPT 78802 if scanning is done over one day or 78804 if whole body scanning is done over multiple days. Code 78804 is only assigned once, not every day that you scan.

If you do limited (not whole body) imaging in addition to the SPECT, code only 78803. Be sure to also assign Level II code A9572 for the radiopharmaceutical if you incur the expense for this material.

**We have a physician’s order for an injection of a chest port in nuclear medicine to check for patency. The physician doesn’t want the patient to have the radiology injection due to complications with the contrast in the past. What code would be used for this procedure?**

The code to assign is CPT 78800 (plus the code for the radiopharmaceutical). Codes 78800–78804 are usually used for tumor localization, but they can also be used in other cases for “distribution of radiopharmaceutical.” This allows for use in cases such as the port check because you are watching the distribution of the radiopharmaceutical to see if the port is open or not.